BUILDING COLLABORATION IN THE NC SYSTEM OF CARE: TECHNICAL ASSISTANCE MATERIALS

Building upon the achievements of the former Willie M. Program and thanks to three federal Center for Mental Health Services grants awarded since 1994, North Carolina is gaining in experience and success in addressing the mental health needs of children and their families through locally-based Systems of Care. These technical assistance materials are offered as a resource to further best practices and collaboration on behalf of North Carolina's children with serious and complex mental health needs, and their families. Additional technical assistance information will be posted on the web. Keep checking this site for updates, articles, answers to questions, and reports.

Instructions

This file of Community Collaborative materials can be downloaded into Microsoft Word or other applications that read Rich Text Format files. You can quickly navigate the downloaded file within MSWord using typical commands like Find and Go To, or print the file to use in hard copy. The samples and tools are included for your convenience. Please feel free to modify them for your purposes, making sure to credit original authors whose names appear in the document.

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Sections

These materials are divided into three sections.

Section 1: (pages 1-20)
Responsibilities of Community Collaboratives in the North Carolina System of Care

This section contains information about the responsibilities of Community Collaboratives and suggestions from communities that have already developed Collaboratives.

Section 2: (pages 21-26)
Child and Family Team Meetings

This section contains information about setting up and running initial Child and Family Team meetings to successfully develop plans that reflect System of Care philosophy.

Section 3: (pages 27-70)
Tools, Samples and Other Materials

This section contains samples and tools from a variety of sources that may be helpful in your Collaborative efforts. *Feel free to change materials in this section to meet your needs. Remember to credit original authors in your changed version.*

SECTION 1

Responsibilities of the Collaborative

Who Serves

The Community Collaborative will serve as the body that supports and oversees their community's Child and Family Teams and the development of their local System of Care.

Area Program, DSS and DJJDP staff should work with each other and with families and family support organizations to develop the Community Collaborative. They are encouraged to build upon existing collaboratives.

must have representation from Area Programs, DSS, DJJDP and families per legislative mandate; must be people with decision-making authority.

strongly recommended that local schools, Guardian ad Litem Offices, community organizations, the faith community and other interested parties be represented.

Responsibilities of the Collaborative

Below is a list of fundamental responsibilities of the Community Collaborative.

- Oversee and Monitor Waiting Lists and develop criteria for prioritizing waiting lists with attention to priority populations.

monitor the wait list...

The Collaborative makes projections based on budget information and numbers of children needing services. Children who will not immediately receive services through the At Risk Children's Program Funding stream are placed on a waiting list.

Note: Children on the waiting list are not denied services. They are served to the best of the community's ability to meet their needs even if At-Risk Children's Program funding is not immediately available.

Waiting list names are entered on the At-Risk Children's Program Wait List Survey, a special scanable form for recordkeeping and information sharing.

The At-Risk Coordinator sends completed waiting list forms to the office of Data Operations. The form is completed each time a child is identified as needing services that are not currently available.

This process is very important because it allows the state office to collect data to support requests to the legislature for increased program funding and to identify regional gaps in

service.

develop wait list criteria...

Follow priority populations guidelines (see definition of priority populations) and develop decision-making strategies for determining who gets served. There are many ways to approach this task, for example voting plus polling absent members or forming a wait list subcommittee. According to the Attorney General, as long as collaboratives are not capricious nor prejudicious in their approach to determining waiting lists, there is no legal liability.

Focus Efforts on Serving...

• Former Willie M. class members

• Children who are at imminent risk at being placed in DSS custody, Youth Development Academies, or state hospital due to lack of necessary mental health services including sexually reactive/aggressive or deaf and hard of hearing youth.

- Evaluate the service needs and gaps of the community.

Use existing survey tools (one is available in these materials) or develop your own survey tool to identify services that are needed, but not available. Try to be systematic, look for trends in service needs, and remember to first consider natural community resources to meet service needs whenever possible. Make sure your survey is a community effort that includes families and all participating agencies.

- Recommend ways to bridge service gaps.

Work together to develop strategies to address unmet service needs. For example, flexible funding, grant application, volunteer efforts, and creative use of community resources.

- Lead agencies, families, and providers should collaboratively share resources and decision-making with the local agencies/providers to ensure an adequate continuum of appropriate services and supports in the catchment area.

Collaboratives should strive to reduce agency boundaries in an effort to provide the most appropriate services. In other words, whoever is best suited to provide a service, should do it. This level of sharing requires that collaborative members be people who are empowered to make decisions and accept responsibility for service provision.

Community Collaborative Expectations and Initial Tasks

This list of expectations and initial tasks for Community Collaboratives reiterates and defines some of the Collaborative's responsibilities outlined above. In addition, it includes some guidelines and strategies for accomplishing Collaborative responsibilities.

Develop bylaws for the local Community Collaborative that address (but are not limited to) such issues as: meeting frequency, location, membership, chairmanship, working committees, etc.

Sample bylaws are included in the Tools/Samples section of these materials.

Develop plans to ensure confidentiality of the cases/issues that may be discussed with the Collaborative.

Crisis response plans to divert or resolve a crisis are developed along with the comprehensive treatment plan.

Act as a review board for At Risk Children's Program eligibility decisions. Conduct appeals process for these cases as necessary.

The Collaborative is the place where eligibility decisions can be appealed. They can review decisions and check to make sure that:

- all the appropriate people were at the meeting, including the referring party and family
- information was gathered correctly
- forms were filled out correctly and completely

The Collaborative cannot allow children who do not meet eligibility criteria to access funding.

Work with other interagency groups to streamline the process of meeting regularly. Work to merge these groups/functions where possible.

Establish plans to facilitate communication between Child and Family Teams and the local Community Collaboratives.

Support the work of the Child and Family Teams by examining the barriers to

service and working collaboratively to overcome these obstacles.

Information about Child and Family Teams is included in these materials.

Educate one another about services and roles each agency or organization can contribute to the collaborative effort.

Survey local formal/informal resources for children and families in the area.

Use the above to develop a needs assessment that identifies local gaps in services as well as services that could be looked upon as regional level referral programs. Communicate the results of this assessment to the state office (Stephanie Alexander). The Assessment should be completed and turned in by October 1 of each calendar year.

Research and apply for grants to help fill the service gaps and enhance existing services.

Work with other local Community Collaboratives in the region to partner with when assessing methods of filling service gaps or developing regional type services.

Work collaboratively to develop a training needs assessment for the area. Develop a training plan based on these needs and available local/state resources and monitor training implementation.

Work to ensure that all available natural resources are brought into the North Carolina System of Care.

Encourage the growth and development of local Family Support Groups for caretakers of children with Serious Emotional Disturbances. Build upon existing resources in Area Programs, NAMI, SOC Grant Site Groups, Mental Health Associations, Local Faith Community or other Community Agencies. The Collaborative should work to ensure that families are receiving the support they need to maintain children in the least restrictive treatment that is appropriate.

Remember, a main goal is to divert children from inappropriate DSS custody, training school or state hospital placements.

Develop and manage the Waiting List for services based upon State delineated Priority Populations.

Maintain a list of children successfully diverted from inappropriate DSS Custody, Training School (Youth Development Academy) placement, or State Hospitalization due to lack of access to appropriate mental health treatment resources. Supply this list to the State as requested.

You will be sent a scanable form for this purpose.

Work toward developing a flexible funding pool to meet the needs of children and families. This could include dollars/services pledged by participating agencies for use in novel or unconventional manners.

Ensure family members are represented at every level of the System of Care.

Ensure that evaluation/QI/QA activities occur and outcomes are used to inform decision making and improve functioning and services at the community collaborative, programmatic, and service delivery levels.

Work collaboratively to create shared ownership by pooling resources such as creating blended positions, programs, etc.

Background

Collaboration at All Levels

Child and Family Teams
Community Collaboratives
State Level Collaborative

System of Care Approach

The At-Risk Children's Program funding stream will apply a System of Care philosophy to provide a comprehensive spectrum of mental health and other necessary services and supports, organized and coordinated to meet multiple and changing needs of children with specific mental health needs and their families.

Based on two core values, System of Care is:

1. **Child- and Family-Centered**

   - services are adapted to the child and family's needs

   - services enhance the personal dignity of the child and family

   - child and family are involved in treatment planning and delivery

2. **Community-Based**

   The community is the primary locus of services/supports and decision making.

Child and Family Teams (CFTs)

The services delivered to children and their families through the At-Risk Children's Program funding stream will be planned and coordinated though Child and Family Teams**.** Team members will be front-line agency staff, the family, and other stakeholders directly involved in the treatment of the child and family. The Child and Family Team will work in full partnership with the family to make treatment and service decisions and to deliver those services. Case Managers and families are the lead members of the CFT.

Information about Child and Family Team meetings is included in this document.

Community Collaboratives (CCs)

The Community Collaborative will serve as the body that supports and oversees their community's Child and Family Teams and the development of their local System of Care.

Area Program, DSS and DJJDP staff should work with each other and with families and family support organizations to develop the Community Collaborative. They are encouraged to build upon existing collaboratives.

State Level Collaborative

A State Collaborative has been developed, comprised of representatives from DMH/DD/SAS, DSS, DJJDP, families, family advocates and other stakeholders. This collaborative will address policy concerns and oversee and serve as a resource to Community Collaboratives to promote success at the local level.

Things to Know about Organizing Collaboratives

Notes and Ideas from NC Communities

The following is a composite of information and ideas gathered from communities that have already established Community Collaboratives. Many of the lessons learned can be generalized to help your Collaborative.

Step 1 – Identify Members

- Identify family members in the system who can be involved in the organizational process of the collaborative.
- Identify community leaders, especially those who are involved with children.
- Identify the appropriate representatives from Mental Health, Schools, Department of Social Services, Juvenile Justice, and the Health Department. In multi-county situations, identify an agency representative from each of the agencies in each of the participating counties.
- Identify other agencies and organizations in the community(ies) that have a strong interest and involvement with children and youth.

Step 2 – Assess the Community

- Identify other initiatives or projects in the community that have consistent philosophies or goals that are consistent with System of Care.
- Multi-county projects need to determine which counties will be included and assess each individual county.
- Learn about the structure and purpose of other consistent initiatives

  Who is meeting?

  When are they meeting?

  What is done in the meeting?

  Is the group strongly committed?

  Is there a governmental or legal mandate to have this group?

  Is someone from your agency already participating in that group?

  Is the group receptive to broadening its mission?

Step 3 – Organize an Initial Meeting

- If there is an existing group that can be used or built upon, meet with that group leader and representatives to discuss how the two might fit together. In some cases, two initiatives cannot have joint oversight committees but can collaborate on certain objectives or projects.
- If there is not an existing group to work with, get a few key leaders from the community together to plan the first organizational meeting. Parents must be involved from the beginning.
- Set a date, time and place for the first meeting. Determine the agenda, keeping it informative but brief. It should include a discussion of purpose, membership, organizational structure, established meeting times and place, etc.

See a sample meeting agenda included in the Tools/Sample section.

Step 4 – Establish an Organizational Structure

- Educating the membership is vital. A training or retreat can be the basis for a successful collaborative.
- Write bylaws to guide the collaborative and committees.

See sample bylaws included in the Tools/Samples section.

- Establish committees with committee chairs that will support the mission. For example:
    1. Family Organization Committee – the purpose would be to help establish and maintain a family support, advocacy and education group for families and youth with SED.
    2. Communications Committee – The purpose would be to promote community awareness and public relations for the project.
    3. Training Committee – the purpose would be to assess training needs, learn about existing training opportunities, and arrange the necessary SOC training in all the agencies.
- Each committee needs to establish goals and develop an action plan. Committees should report activities at each meeting.
- Other issues for the following years will be:
  - incorporation, protocols, budgets, etc.

1. What Has Worked?

Response 1 – Identify and Combine

"We decided to focus on strengths and pulled together the strengths of partners from three counties. We began by exploring the human and service resources that each county could contribute to the collaborative and in the process identified infrastructures, procedures, and forms already in place that we could use without reinventing the wheel. "

Response 2 – Take Time Up Front to Build Rapport

"In our community we dedicated time to two retreats. The first one was a two-day retreat that focused on defining our purpose and vision and ensuring that we all agreed to our shared responsibilities and were committed to "collaboration." The second retreat (about 6 months later) focused on getting balanced representation in our community collaborative membership because at that time we felt we were too heavily represented in some areas and not represented enough in other areas. These processes helped us learn how to work together to make joint decisions."

See a sample retreat agenda in the Tools/Samples section of these materials.

2. What Has Not Worked?

- It does not help to rush the process.
- Initially, our collaborative formed a group with no training nor discussion of how to begin operating as a collaborative. Dictating tasks and reporting what a few of the members had done with no input from the Collaborative created tension and made some members skeptical.
- It does not work to assume, even with a group that communicates well, that people all agree on what collaboration means, much less know how to do it.
- It has not worked when the people at the collaborative table did not have the power to make decisions. You don't have to have agency directors at the table, but you must have people with some decision-making authority.
- It does not work to invite people to the table who are not ready to roll up their sleeves and work together to:

  - challenge the systems they work within

  - take some risks

  - be willing to communicate Collaborative efforts, purpose and tasks to the other people within their agencies

3. What Would You Do Differently?

- Make sure there is broad-based representation. We should have started our Collaborative with more diverse representation; more non-mental health staff.
- Take time to get buy-in and commitment.
- Take time to educate one another about the roles and responsibilities of each agency or group, e.g., Mental Health, Child Protection, DSS, etc..
- We should have begun the process by giving the initial group a chance to assess strengths and abilities and to commit to this process. This effort is so intense that people tend to "support" efforts in theory, but not necessarily "commit" to change. Collaboration is darn hard work.
- Orient members of the Community Collaborative. We should have had an orientation for all collaborative members before they began attending meetings so they could have known the purpose and scope of the Collaborative before they started. Along the same lines, it would have been helpful if we had understood how critical it is to make sure that parents are at every meeting. We should have spent time up front getting to know parents and helping them learn. It is too easy to talk a different language from parents and still leave them out of the process, even with them sitting at the table.
- Measure progress. Develop a process or plan by which you measure your Collaborative's progress. The Collaborative's outcomes may be the first, most important things to measure.
- Consolidate as much as possible. Combine similar efforts early on as the collaborative is formed. Although that can become overwhelming to members (which it was for us when we began to do this), it reduces the number of meetings you must attend if you consolidate meetings and efforts surrounding similar issues.
- Arrange meeting agendas to accommodate special requests and needs. We learned that input from families wasn't heard by all collaborative members because often parents had to leave meetings early. We now have family input at the beginning of the agenda.

4. What Resources Did You Use?

- The collaborative members kept saying DSS representation was needed and now DSS is part of the team.
- We used local resources for training and leading our retreats. We also used some technical assistance from the State.
- We used each other for training and developed plans and bylaws that would guide our functions. For example, we said that no issues/barriers will be discussed without the partner involved being present. The group reminded us to follow that rule.
- We have involved collaborative members to date from each public agency (Juvenile Justice, DSS, Mental Health, Health Department, Public Schools), private non-profit (Mental Health Association and current leader of the development of the family organization—SUCCESS), five parents, local university or Community College faculty, and committee chairs.

5. What Other Resources Did You Need?

- A communication consultant to establish a communication plan would have been helpful.
- We needed a training-communication sub-committee that could feed data back to the project oversight committee to identify needs of the communities.
- Training in collaboration at an earlier stage of the game would have helped our process.

Ensuring Family Participation

The following are comments and ideas about ensuring full parent involvement in the planning process gathered from communities that have already established Community Collaboratives.

1. What Worked to Get and Keep Parents Involved?

- Formalizing family involvement by building infrastructure like a speaker's bureau of parents to be presenters and trainers.
- Timing with other initiatives in the community created a positive movement.
- Providing stipends for parents to attend training, special meetings, etc. Payment for time and services puts parents on an equal playing field with their "professional" counterparts who are paid for similar activities.
- Paying parents to be co-presenters at trainings.
- Professionals seeing that better outcomes are possible with parent involvement.
- Encouraging candid discussion. Open, outspoken parents really helped our communication progress.
- Having funds to provide meals at parent support meetings.
- Having professional who already had a background or a mindset in family-centered practice.
- National conferences at which professionals had contact with local as well as parents from other communities.
- Offering parent-focused training.
- State office pushing for family involvement.
- Having regular family support meetings.
- Having opportunities during parent meetings for them to meet with community providers.
- Families feeling they have a voice; sometimes through the family advocate.
- Getting information out to families i.e., announcements, articles, etc.
- Exposing family members to things that only professionals are generally exposed to.
- Flexibility.

2. What Hasn't Worked?

- Having too much involvement from professionals.
- Double standard for parents. Sometimes the standards for professionals are not applied to parents . For example, when parents are being paid to do something, they are told that they will be paid rather than asked what they will charge. There seems to be no room for negotiation as there is when professionals are hired to do something.
- Professionals not valuing parents' experience as much as they value experience of other professionals.
- Wavering buy-in by agency heads.
- Involving parents without full orientation.
- Expecting parents to know business, human service and advocacy overnight. Parents feel like they are being thrown into the ring.
- One token parent does not work. Need a broad-base of parent representation.

3. What Would You Do Differently?

- Would link with an existing organization whose vision and mission could be expanded to also focus on advocacy and leadership for children with SED.
- Take more time to train and educate families about the system.
- Take more time in general. Understand that it is a process, not an event.
- Find out first what people (especially family members) think you should be doing.
- Set reasonable expectations for parent involvement. Give them time to feel comfortable before expecting them to take on big tasks.
- BE realistic about what it takes to create and build the infrastructure for a non-profit agency.
- Understand that best practice is best practice no matter what the organization.
- Divide and balance tasks, especially labor-intensive tasks. For example, the parents who are helping with recruitment cannot be the same parents who are building the organization. They are both time-intensive tasks and require different skills.
- Make sure that parents who are (will be) living with the decisions being made are the ones at the table.
- Pay more attention to impacting the individual child while working to change the system. Parents think they are making things better for their children today. This may or may not be the case.
- Train agency members to work openly and effectively with parents (Making Room at the Table types of training).
- Get broader base of participation from existing family groups rather than create new ones.
- Promote understanding that a System of Care was the goal, not the starting point.

- Incorporate parent organization into an existing organization for an incubation period (several years). It is asking too much of parents to have them participate on committees, collaboratives, build the organization and at the same time be there for their children.

4. What Other Resources Did You Need?

- Training to support families as real partners.
- Real effort at training and framework on what is a good way to go about family involvement. What would it take to make this a reality?
- Capacity by state office to provide support and consultation in helping communities create real parent partnerships and involvement.
- Need someone or group who can systematically and specifically work with families to address issues of family involvement and leadership.
- Someone to help families with an organization development plan.
- Formal (signed) buy-in from agency heads.
- Money, support, technical assistance and training to develop parent organizations.
- Training for parents on how to set agendas, run meetings, serve on boards and committees.
- Mechanism for parent training on Child 7 Family Team process with parents as co-trainers.
- In order to be equal partners, parents need opportunity to learn the languages of DSS, JJ, MH, etc.
- Training on how to confront the confidentiality issues.
- Orientation on processes of change and the dynamics of collaboration.

5. Recommendations

- Make sure parents are included at **every** level of the process.
- Schedule meetings at times when families are more apt to attend (often that means no meetings during usual working hours).
- Use an assessment process to determine where families strengths are and then have them decide what they want to do.
- The key to being successful in their process is to begin to see each other as people. Spend time together building relationships. It is what will help everyone weather the storms that will inevitably come.
- Let people know you appreciate them and their commitment.
- Give something in return. Don't just keep taking.
- Equal partners happen as a result of training and substantial involvement. Professionals need to be honest about where they are in the process; openly look at where the partnerships with families are weak and address that. Do not have meetings with only professionals present to talk about families.
- Recognize and validate different perceptions and perspectives.
- Plan how you will bring individuals and communities together.
- Have a TA person and training person from the State develop resources.
- Old habits die hard. Professionals must be committed to educating parents about the system.
- Understand that advocacy for parents can be a difficult and conflicted role given they often relive the pains they experience with their own child.
- Be sensitive and remember that parents, above all else, are concerned about their children. Many parents are not ready to use words like brain disorder to describe their child.

Questions and Answers

The following questions and answers are based on interviews of several communities that have already developed Community Collaboratives.

How do you ensure real collaboration and joint decision making?

It was obvious from the outset that we needed someone to help keep us on track, communicate better and work together, so we established a "process checker" to give us feedback on our collaboration skills throughout our meetings. We are getting much better at giving and receiving collaboration feedback and using it to improve the process.

We now have a Standing Reports portion of the agenda to make sure that we hear reports from subcommittee. We recently started to rotate the order of the agenda to make sure that each reporter gets a fair share of time and attention.

How do you develop agendas for your Collaborative meetings?

We have several committees in operation so to make sure that things run smoothly, we have a monthly Committee Chair meeting to set the agenda a week to ten days before the each Collaborative meeting. Taking time as a group to set the agenda before the Collaborative meets has resulted in agendas that are more on-target than when the chair alone tried to develop the agenda. So far, there have been no complaints about agenda issues.

How have you structured your CC to share the work load?

We developed six committees – family integration, training, finance, service, delivery, research, and public awareness – to distribute the workload across the Collaborative. Having committees has also created opportunities for more people to be involved in the process without the drawback of expanding the Collaborative to an unmanageable size.

How did you help parents take an active role at the meetings?

We developed ground rules and bylaws to guide us and eventually created an environment in which parents felt comfortable speaking out. Over time we began to trust one another to give honest feedback. We now have conversations and planning sessions that get to the core of what we need to do. Parents keep the rest of us honest.

Two things that have worked very well are: (1) involving more than just a couple of parents and (2) preparing parents better before they come to the table. Retreats helped parents tremendously to become equal partners at our table. Parents don't hold back once they realize their purpose and that helps us stay focused too.

What outside resources helped?

We have had some hurdles to overcome, but I'm also not sure that any outside resources could have helped us get where we are any quicker. Although you may need other resources, each community wants to be independent and develop things their own way.

SECTION 2

Child and Family Team Meetings

Applying the Steps

Child and Family Team Coordinators are encouraged to follow some common sense steps to ensure that meeting processes and treatment plans are in keeping with a System of Care philosophy. The steps given below are one example of many ways a meeting could be organized and facilitated. Your meetings might have a different format, which is fine as long as System of Care goals are met.

Step 1: Introduce the Team

The Coordinator asks people to introduce themselves by describing their relationship to the child. The Coordinator goes over meeting ground rules and confidentiality expectations.

> Child and Family Teams should not include people who do not know the child or family.

Step 2: Review the Strengths Inventory

The Team Coordinator reviews the initial strengths discovery that has taken place prior to the meeting. Participants are encouraged to suggest additional strengths.

> A review of strengths starts the meeting on a positive note. Participants are reminded that the detailed list of strengths will be used to create helpful strategies later in the meeting.

Step 3: Review the Current Situation.

Team members comment about the current situation. The focus is on current circumstances that the team may need to be aware of.

> Facilitators ask people to be BRIEF and to focus on the PRESENT situation, not give a detailed oral history.

Step 4: Set and Prioritize Goals

The Coordinator leads the team in a discussion about goals for the child and family. Goals are stated and recorded on a flipchart in ordinary language that makes sense to family members. The Team prioritizes goals to focus the meeting on no more than three or four goals that are meaningful to the child and family.

Some Strategies:

The Coordinator may start by asking the team to consider an important area of the child and family's life such as home, school, safety, behavior, family, juvenile justice, etc. Then the Coordinator will ask the team to visualize their desired outcomes for the child and family. Coordinators may ask questions like "How do you want things to be a year from now?"

Or the Coordinator may ask the team to think about another child of similar age, neighborhood, culture, etc. who is "doing okay." Then the team describes behaviors or circumstances that help that other child "do okay." These characteristics may suggest goals for the child and family that is being served.

Step 5: Identify and Prioritize Needs

The Coordinator focuses the Team on one goal at a time. He/she leads a discussion about what will need to happen for the goal to be achieved. If the list of needs is long, the Team prioritizes the most urgent needs.

Step 6: Identify Strategies that Focus on Strengths

The Coordinator asks the team to suggest strategies that can help meet each need that has been listed. The Coordinator refers the Team back to the strength inventory to stimulate ideas for strategies that may have the best chance of working.

It can take a lot of creative thinking to come up with effective strategies. Coordinators should encourage people to think "outside the box" and to use informal resources that are often overlooked.

Most of the strategies will be related to a strength of the child, family, or system. However, some people may suggest strategies that are not directly related to a strength. The Coordinator may then ask, "Why do we think this strategy will work? Is there anything in the strength inventory or any other evidence to suggest this strategy may work?"

Step 7: Obtain Action Commitments

Individuals volunteer or are assigned tasks related to each strategy. The Coordinator will focus on other goals and repeat Steps 4 through 7 as time and circumstances allow. Team members sign off on the plan.

Step 8: Develop a Back-Up Plan

The Coordinator asks the Team to consider what will happen if the plan does not work. A back-up plan (or crisis plan) is created.

Step 9: Get Closure

The Coordinator reviews plans and sets future meeting time if appropriate.

Facilitator's Planning Checklist

Before a Planning Meeting

- ❒ read referral information or other relevant background information
- ❒ meet the child and family
- ❒ conduct a strengths discovery
- ❒ create a preliminary meeting agenda with the child and family
- ❒ decide with the child and family who needs to participate in the meeting
- ❒ establish a workable meeting time and place
- ❒ contact and invite members of the team to participate
- ❒ tell team members why they are needed at the meeting and ask them for advice about the most important life domains to focus attention
- ❒ anticipate potential problems for the meeting and prepare your response
- ❒ prepare flipchart to include meeting agenda and summary of strengths

During a Meeting

- ❒ create a friendly environment and encourage everyone's participation
- ❒ explain rules of confidentiality and get forms signed, if necessary
- ❒ explain meeting ground rules and give an overview of the agenda
- ❒ summarize and modify the strengths inventory
- ❒ set *normalized* goals for one life domain
- ❒ help the team identify and prioritize needs that are barriers to the goal(s)
- ❒ help the team identify strength-based strategies to meet the needs
- ❒ list assignments for completing strategies and get commitments from team members
- ❒ create a crisis plan as an alternative for any strategy that the family thinks might break down
- ❒ repeat the planning steps for additional life domains if time and circumstance allow
- ❒ set time for the next meeting and evaluate the meeting process

After a Meeting

- ❒ write the plan on the project planning form
- ❒ send or deliver copies of the plan to team members
- ❒ monitor progress by communicating with team members about assignments, strategies, and outcomes
- ❒ assess the need to reconvene the team or to modify the plan

Contact Sheet

You may want to use this contact sheet to help your team work through the process of identifying potential Child and Family Team members.

SECTION 3

Tools, Samples and other Materials

Steps in the Collaborative Process:

A Planning Tool

The following guide is best used as a menu of topics, not a blueprint, for thinking about and addressing issues and activities that are central to collaborative efforts. The questions presented below are drawn from the experiences of a wide range of collaboratives and as a result are likely to apply to a variety of issues. It is not necessary to answer the questions in the order that they are given nor to answer all of the questions. However, collaboratives that are just getting started should consider answering many of the first questions before tackling the more complex issues that are addressed by the remaining questions.

> This is a menu of topics. Choose and use the steps you need.

Step 1. Decide

a. Should your organization participate in a collaborative initiative?

b. What costs and benefits are involved in this decision?

c. How well prepared is your organization to be a quality partner in a collaborative, including ability to allocate time and other resources to fully participate in the process?

Step 2. Determine Vision and Motives

a. What motivates you to be involved in your collaborative initiative?

b. What do you want to accomplish through your involvement?

> Before beginning a formal discussion about vision, divide the group into pairs and ask them to interview each other by asking the two questions above. Ask volunteers to report partners' answers. Make note of key words and phrases. Use these words and phrases to write starter sentences for a vision statement that reflects the thinking of the group. Use this first draft as a basis for further discussion and refinement.

Step 3. Figure Out Who Should be Involved

a. Who is currently involved in your collaborative?

b. Are those who will be most affected by the collaborative currently involved?

c. Who else should be involved?

d. How will you involve them?

e. How can you involve and ensure participation of those who are traditionally excluded from decision making?

Step 4. Set Expectations

a. What expectations should you have for each other?

b. What are some basic ground rules participating partners should follow?

Step 5. Identify the Mission

a. What is your collaborative's mission?

A mission can be defined as a simple, clear statement of purpose that is also a call to action.

Step 6. Determine Goals and Objectives

a. What are the goals and objectives of your collaborative?

A goal can be defined as a long-term activity to implement a mission and as a measure of progress toward achieving a mission.

An objective can be defined as a short-term activity to implement a goal and as a measure of progress toward achieving a goal.

Step 7. Figure Out Roles

a. Who will get the work done?

b. How can you link specific individuals and organizations to the specific objectives to ensure that the objectives will be carried out in a timely way?

Step 8. Learn from Other Similar Efforts

a. What do you know about other collaborative efforts that have worked on a similar mission or goal?

b. What are some lessons your collaborative can learn from these efforts?

> System of Care demonstration sites in North Carolina already have a track record for establishing Community Collaboratives. You can learn from their examples.

Step 9. Identify Resources to Share

a. What can each partner contribute to the collaborative?

> When making your inventory of resources, remember to think broadly to include a wide range of resources (financial and non-financial). For example, a partner who brings credibility and access to the community adds something as valuable as any financial contribution.

Step 10. Encourage Participation

a. How does the collaborative identify and encourage new members to participate?

b. How well are new members informed about roles, responsibilities, and rewards of participation?

c. How well do participants reflect the diversity of the communities that the collaborative serves?

Step 11. Keep them Involved

a. What incentives and rewards can be used to recognize and sustain partners' contributions to the collaborative?

b. How can you acknowledge changes individuals and organizations have made in their policies and practices to become consistent with the collaborative's vision, mission and goals?

Step 12. Decide about Governance

a. How is your collaborative governed?

b. How will governing responsibilities be rotated over time?

c. How will governance reflect and respect the collaborative's diversity?

Step 13. Examine Leadership

a. How effective is your leadership?

b. Who is providing leadership for your collaborative?

c. How adequate is the leadership team?

d. What might be done to support and improve leadership?

e. How are new leaders identified and rotated into key positions?

f. What expectations do you have for collaborative leadership?

Step 14. Examine Management

a. How is your collaborative administered and managed?

b. Are the arrangements adequate? If not, how can you improve the administration and management of your collaborative?

Step 15. Staff the Collaborative

a. How is staff provided for your collaborative?

b. How is staff accountable to the collaborative?

c. If staff is being provided by a partner or partners, what challenges does this arrangement present?

Step 16. Know Barriers

a. What barriers or conflicts make progress difficult?

b. How can such conflicts and barriers be resolved or overcome?

> This is a good opportunity to apply System of Care strength-based approach thinking. In this case, identify strengths and use those strengths to overcome barriers.

Step 17. Provide Training

a. How does the collaborative train its members on topics such as group process, conflict resolution, and cultural diversity and inclusiveness?

b. How can this training be helpful in addressing and resolving important issues?

Step 18. Get the Word Out

a. How will people find out about your activities?

b. How will you provide effective community education about the collaborative?

c. How will you inform and engage people of diverse ethnic, cultural and language backgrounds?

d. Do you communicate regularly and effectively with grassroots groups?

Step 19. Focus on Funding

a. How much money will you need and how will you secure it in a timely manner?

b. What kind of funding sources will you need?

c. Is there a written financial plan including strategies for implementation?

d. Has the collaborative made sure that the organization through which funding flows does not have greater decision-making authority because of its fiscal management role?

Step 20. Monitor Progress

a. How will you monitor progress and evaluate the overall success of your collaborative?

b. How will you monitor and evaluate processes, products, and outcomes?

c. How will you use evaluation results to make changes?

Adapted from:

"Collaboration for a Change: Definitions, Decision-making models, Roles and a Collaboration Process Guide" by Arthur T. Himmelman

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Sample Retreat Agenda

Purpose:

To create a common vision for the future of the Cleveland County System of Care.

Goals:

Revise the mission statement of the Community Collaborative.

Create an outline for an Interagency Protocol that will guide interagency teamwork and the behavior of people on Child and Family Teams.

Create a plan to support and sustain the Cleveland County parent group.

Day 1 Agenda

9:30 Registration and Coffee

Welcome and Introductions
Community Collaborative Chair

Purpose, Ground rules, and Agenda

10:00 Start with what's working. A Strength Assessment of the System of Care
Distribute Agency Asset Tool
Conduct small group discussion of local strengths and report out

12:00 Lunch

1:30 Mapping the Future: Creating a Common Vision
Facilitated Discussion Groups to Set and Prioritize Goals
Parent Group, Administrator Group, and Service Provider Group

2:30 Group reports and feedback

3:15 Break

3:30 What will it take? Identifying what needs to happen to achieve the vision.
Facilitated Discussion Groups to List Needs
Parent Group, Administrator Group, and Service Provider Group

4:30 Group reports and feedback

5:00 Refocus for tomorrow and adjourn

Day 2 Agenda

9:00 Saving the System of Care: A Team-Building Activity

10:00 Where do we want to start right now? Prioritizing needs.

10:00 How are we going to get there? Creating a Plan - Part 1
Small group discussion to list possible strategies to meet system needs
Parent Group, Administrator Group, and Service Provider Group

10:45 Break

11:00 What about an Interagency Protocol? Creating a Plan - Part 2
Distribute the Buncombe Co. Interagency Protocol
Conduct large group discussion to build an outline of a hypothetical Cleveland County protocol

1200 Lunch

1:30 Now the Hard Part: How do we guarantee families voice, access, and choice?
Small group discussion to list recommendations to support the parent groups

2:30 Break

2:45 Group report out and discussion

3:15 What have we done and what will we do next? A summary of the mission, goals, needs, and strategies

4:00 Evaluation, feedback, and adjourn

Sample CC Meeting Agenda

6:00 – 6:10 Welcome and Introductions

6:10 – 6:30 Committee Updates
Child and Family Teams
Federal Site Visit
Training

6:30 – 7:00 At Risk Update
Update from At-Risk Coordinator regarding budget and waiting list

Continue discussion of eligibility criteria, specifically "OTHER" category.

7:00 – 7:20 Service Gaps and Budget Considerations
Prioritize service needs based on gaps identified at our last meeting. (See minutes dated 3/15/01)

For discussion: How to pool SOC funds with other funds to close service gaps. Continue discussion of eligibility criteria, specifically "Other" category.

7:20 – 7:40 Web Site
Demonstration of our new Web site. Feedback from CC members.

7:40 – 8:00 Time Line for Public Awareness Campaign
Review our Draft Communication Plan and develop a timeline for implementing the public awareness components.
(See minutes dated 3/15/01)

8:00 – 8:15 Set Date and Agenda for Next Meeting

Collaboration Lessons Learned

Based on an interview with Bibba Dobyns, Director of the GIFTTS program in Guilford County, part of North Carolina's System of Care initiative.

GIFTTS is a NC System of Care project site that has been steeped in "collaboration" with a focus on community-based and strength-based treatment and commitment to family involvement for years. The experiences of GIFTTS may be helpful and encouraging for communities that are just starting their At-Risk Children's Program Collaboratives.

As Director of the GIFTTS project, I had to learn quickly about getting people to work together. I think the biggest lesson learned is that collaboration is hard work, especially in the beginning. If I were starting over today, I would approach the process differently, recognizing that before a group can work together, they all have to be on the same page, recognize that system change is critical to better outcomes and accept responsibility for making that happen. Real buy-in from management and Collaborative members is what matters. By "real by-in" I mean a level of understanding and commitment beyond just saying "I support a System of Care." I would want people to also say "and this is what I will bring to the table."

Even with a plan and the best intentions, there's no getting around the fact that true collaboration takes time and patience. Members come into the Collaborative with different levels of commitment and readiness. You have to start where they are, and be careful to not rush the process. Fortunately, there are ways to facilitate the process. For example, we found that a retreat to jointly develop a mission statement, set goals, and establish working rapport can really help the process along.

It also helps to start the Collaborative with members who are empowered to make decisions. It does little good to make elaborate plans if Collaborative members are not in a position to commit time, staff and funds to support them.

I came to the GIFTTS System of Care project after the first year of the grant, at the time Mental Health took over as the lead agency, At that point, we had a lot of people at the table, but we were far from collaborating. One thing I did right away was to meet with every member individually to get their views. Interviews turned out to be a good exercise that gave people a chance to express their interpretation of the grant. However, I soon realized that group members had differing interpretations and definitions which were getting in the way of progress. That realization prompted our first collaborative retreat.

The retreat was a healthy forum for open discussion which helped us over some hurdles. Eventually, we were pointing out strengths to each other and shifted our focus to identify what we could all offer. At the same time, we committed to discussing "hot" issues, even if they made us uncomfortable. A second retreat gave us time to work on some of those specific "hot" issues. Now we try to have a retreat annually because they have proven to be

valuable at so many levels of collaboration.

I guess the other big lessons learned are, “condense, prioritize, and expect change.” We learned the hard way that we were taking on too many things at once. It makes good sense to put mechanisms in place and combine whatever can logically be combined to reduce redundant work, meetings, and forms.

Training is an example of a beneficial mechanism we put in place. We used a train-the trainer model to train our own staff at each agency so we could respond quickly in a concrete way when training needs arose. And we’ve developed protocols and forms to help us function more efficiently. Sometimes it seems like a mountain of paper, but in the end most of it has helped us get and stay organized. Our bylaws is an example of a document we developed early on that has served well to organize our governing process.

A copy of GIFTTS’ bylaws is included in the Tools/Samples section of these materials.

Membership

Our Collaborative is rich in human resources, but not complete. Right now we have representation from Mental Health, Public Health, Public Schools, local businesses parents, private non-profits, Juvenile Justice, UNC-G, and the Mental Health Association. We would also like representatives from the faith community and the police department. Sometimes we don’t have as much parent representation as we would like, but we’re trying to overcome that problem by alternating daytime and evening meetings to make it easier for parents to attend.

Structure

Our larger collaborative meets once a month; subcommittees meet at least once a month and sometimes more often. Additional Collaborative meetings are called when there is a special need, for example to explain a new initiative.

Right now we have four subcommittees that meet regularly. They are:

1. Training and Communications Committee

This group focuses on developing training to fill knowledge and skill gaps identified through our Quality Improvement efforts. We have trained our own team of trainers so we have the capacity to train new staff as they come in. The training group also collaborates with the University [UNC-G] to develop curriculum that supports System of Care philosophy and practice and to bring parents into the classroom. A subgroup of this training committee is implementing a cultural competency training plan.

2. Research and Evaluation Committee

This subcommittee oversees all of the quality improvement and data collection and analysis functions and shares information with UNC-G faculty and parents.

3. Public Awareness Committee

This committee carries out our public relations plan with a focus on educating the public. We've struggled a bit with public relations because of the time commitment required to do effective PR work, But now we have a standing committee and seem to be making good progress toward educating various Boards and the community about what we are doing.

(Note: At-Risk Collaboratives are not required to have a PR plan, but may find some form of public communication helpful to inform stakeholders, get buy-in, and recruit community members who can contribute informal resources and services. A sample Public Relations plan is included in the Tools section of this document.)

4. At Risk Sub-Committee

This committee was formed to carry out At-Risk Children's Program responsibilities such as managing waiting lists and processing appeals. The At-Risk process has helped by making us more aware of a need for collaboration in client-specific case reviews. We're currently figuring out other details of this committee. Eventually, broad At-Risk functions will be responsibilities of the larger community collaborative.

(Finance Committee)

We started out with an independent finance committee, but have shifted responsibility for finance directly to the Collaborative. That was a big step resulting from improved communication and greater levels of trust among Collaborative members.

Change

Our biggest barriers are the usual: lack of money and shortage of time. I don't know of one peer, supervisor, employee or parent who doesn't have too much to do. And time is not only a staff issue, it's an issue for every Collaborative member. Whereas in the beginning we struggled to figure out our priorities, we now struggle to figure out how to implement change.

If there is one thing to understand it is that you are never THERE – we are forever changing our strategies. In most cases change has been for the better. From the very start we all seemed to recognize a need for change because children in our communities were having trouble and our families needed help. We thought we could do a better job of keeping children safe and in their homes and were ready to commit to making system changes to accomplish those goals. Collaboration has been an important part of accomplishing change in Guilford county.

Sample Bylaws

BYLAWS FROM GUILFORD COUNTY COMMUNITY COLLABORATIVE

Adopted September 4, 1998/Amended January 8, 1999/Amended March 5, 1999. Amended August 6, 1999

ARTICLE I: Organization Name

The name of this organization shall be the Guilford County Community Collaborative. The appropriate acronym shall be GCCC.

ARTICLE II: Purpose of Organization

The mission of the GCCC is to provide a governance structure for the local, collaborative, community based, family driven, fully integrated System of Care.

The goals of the GCCC include:

Ensure access to community-based, individualized, strengths-and community-based, family driven services, which are provided unconditionally and reflect sensitivity to and understanding of, the cultural and ethnic characteristics of consumers and families.

Develop and sustain a full partnership with families and surrogate families in developing and implementing the System of Care.

Integrate local public and private child serving agencies into the System of Care.

Through the service delivery process, compile a list of unaddressed child and family needs, systems issues and barriers to advocate to the State for systems change.

Through partnerships with regional universities and local agencies, provide pre-service and in-service training in the principles, values and practices of the System of Care.

ARTICLE III: Membership

Membership will include at least the following representatives: the committee chairpersons; agency representatives included in the Memorandums of Agreement, SUCCESS representative; eight parent representatives; two representatives from the community at large.

As needed, the GCCC will establish Advisory Committees that could include representatives from a broad range of constituencies and community groups.

ARTICLE IV: GCCC Officers and Committee Chairs

Section 1. The officers of the GCCC shall be elected by majority vote such that:

There is one Chairperson, and there is one Vice-Chairperson

Section 2. A Chairperson for each of the Committees will be appointed by the Chairperson and the Chairperson of SUCCESS.

Section 3. Officers and Committee Chairpersons shall serve one year terms and may be reelected or appointed for an additional term.

Section 4. The duties of each Officer, Committee Chairperson, and lead agency are described below:

The Chairperson will chair and facilitate the meetings; and facilitate agenda development in conjunction with the committee chairpersons, and the staff members.

The Vice-Chairperson will act on behalf of the Chairperson when the Chairperson is absent.

The Chairpersons of the Committees will chair and facilitate committee meetings, and report to the GCCC on a regular basis.

The lead agency or it's designees shall maintain the membership roster of the GCCC; inform the GCCC of changes in membership status; record the minutes of the GCCC and provide staff support for each committee as needed; maintain the "master copy" of the GCCC bylaws.

Section 6: General Powers and Duties

Provide leadership and oversight into Guilford County's System of Care fiscal and programmatic development.

Members duties include communicating activities of the GCCC to respective organizations.

ARTICLE V: Committees

Section 1: Family members are represented on all committees.

Section 2. The Standing Committees of the GCCC with a brief description are:

Finance: Oversees budget development and fiscal and monetary matters; Develops mechanisms to ensure that local, state and federal funding streams are maximized across participating agencies. Service Delivery and Integration: Oversees the development and integration of the System of Care into the community.

Family Integration: Works with the family organization and other relevant groups to ensure involvement of family members in all aspects of implementation of System of Care in Guilford County.

Research, Evaluation and Automation: Oversees execution of all evaluation components and ensures that evaluation results are utilized to improve training and services.

Training and Curriculum Development Integration: Collaborates with community and state resources on training in System of Care values and practice for NC FACES site and other community partners.

Public Awareness/Education: Develop and implement public relations/community education plan on System of Care.

Section 3. Ad hoc committees of the GCCC will be formed and appointed by the Chair as needed.

Section 4. Non-members of the GCCC may serve on committees.

ARTICLE VI: Meetings

Regular meetings of the GCCC will be held at least monthly at agreed upon sites.

All meetings of the GCCC are subject to the Open Meetings Law. GCCC reserves the right to convene in executive session to discuss confidential client or personnel matters.

ARTICLE VII: Amendments

These bylaws may be amended or repealed, and new bylaws may be adopted, with an affirmative vote of two-thirds of the membership at any meeting provided that prior written notice of said amendment has been given at least one week before the scheduled meeting.

ARTICLE VIII: Parliamentary Authority

Section 1. The GCCC will strive to reach decisions by consensus. In the event that consensus is not achieved, decisions will be made by majority vote. Any member may call for a vote. Each member present will have one vote through the formally designated person or formally designated substitute. Family members present will have their vote weighted to ensure at least 50% of the voice.

Section 2. All business of the GCCC, with the exception of emergency business, shall be presented to the members for discussion.

Section 3. Conflicts between members of the GCCC should be resolved by the conflicting members through open and honest discussion. However, if the members are unable to resolve the conflict in this manner, the conflict resolution process will be utilized.

Section 4. The majority of the membership of the GCCC must be in attendance for a quorum. The GCCC will not meet without parent representation present.

Section 5. Members shall notify the Chairperson of their inability to attend a scheduled meeting at least twenty-four hours prior to the date of the meeting. Any member of the GCCC who is absent from three consecutive meetings shall be contacted by the Chair

or Vice-Chair to determine interest in continued membership on the GCCC.

Section 6. Any change in membership shall be in written notice to the Chair.

Ideas for Getting the Word Out

Based on a DRAFT Communication Plan from the Halifax Program

At-Risk Children's Program Collaboratives are not required to have a PR plan, but may find some form of public communication helpful to inform stakeholders, get buy-in, and recruit community members who can contribute informal resources and services.

Goals

- Involve more people in all levels of the System of Care.
- Reduce stigma associated with accessing behavioral health services.
- Increase knowledge within families about ways to access needed behavioral health services and resources within Halifax County.
- Increase awareness within target audiences of the strengths of the Halifax System of Care.
- Increased awareness and participation of parents and families in the System of Care

Primary Target Audiences

- Hard to reach families
- Native American and Latino families

Secondary Target Audiences

- Pastors
- Business leaders
- School principals and counselors
- Masonic organizations, fraternities and sororities
- County Commissioners, Judges, and School Board members
- State legislators

Outcome Measures

- Increased numbers of children referred for behavioral health care and to the System of Care.
- Increased numbers of parents participating in support groups.
- Evaluation forms from public forums.
- Placement of news articles.
- Improvements as reported in Service testing.

Messages

- Every child's mental health is important.
- Many families have problems; you are not alone.
- A collaborative System of Care approach is the best way to help children and families.
- Children within each culture and within each neighborhood of our community have behavioral health needs.
- Behavioral health problems can be recognized and successfully treated.
- Confidential help can be a phone call away.

Strategies to Deliver Messages

- Create a Speaker's Guide for the Halifax System of Care. Make the Guide available to the group of existing volunteers who want to promote the System of Care. Work with TT&CA to produce a 5-7 minute trigger videotape to introduce the presentations.
- Create a brochure to promote the System of Care.
- Organize and implement at least one Faith Forum. The Faith Forum will be advertised to religious organizations throughout the County. The Forum will include a discussion of ways the Faith Community and the formal service system can collaborate to help children with behavioral health care needs and their families.
- Produce a 30 second video public service announcement to promote the System of Care and deliver it to a "contact" at the local television station.
- Collaborate with the Lakeland Theater to recruit youth and adult role players. Create skits to demonstrate typical family situations that could be helped through a System of

Care. Use the role players at meetings, churches, and public forums to “show” the target audiences the messages of the communication plan.

- Staff a booth to distribute information about the System of Care at Downtown/Turnaround and at the Teleforum. Investigate the possibility of distributing information at Walmart.

- Produce a “talk show” about kids, families, and behavioral health to be broadcast on the local cable access channel. Use real parents whose families are served by the System of Care. Promote viewership by mailing announcements to target audiences prior to airing.

AT-RISK PROGRAM UPDATE: THE SHORT FORM

What has Changed?

How the At-Risk Children's Program Differs from the former Willie M. Program

- Now serving a broader population
- No longer an entitlement. Children and youth are not 'entitled' to a particular set of services that extend until age 18. Services are provided within the limits of available funds for a greater number of children. Services last only as long as the money lasts.
- Services are determined "medically necessary" according to Medicaid definitions "Optimal care" standard no longer applies.
- Now a capped amount of money for services and care is available to each Area Program.
- Communities must work among agencies and stakeholders to share and maximize all available funds and resources to pay for a plan of care.
- Eligibility determination no longer based on lawsuit and centralized decision-making. Now eligibility determined locally and jointly by agency, family, and referring party.
- Families more actively involved in the care of their children.
- Family members are the primary partners with the case manager to develop and coordinate a plan of care for their child(ren). Families have an increased role in efforts to improve care through participation in program and policy activities at the community and state level.
- No longer a separate appeals process.
- Only one rate for service payment (corresponds to the Medicaid rate).

What is Similar?

Similarities between the At Risk Children's Program and the former Willie M. Program (building on success)

- Targeted resource development for groups of children ('special populations') with similar needs, e.g., those who are deaf, hard of hearing, sexually reactive/aggressive
- Strives to keep children out of institutions and as close to home as possible.
- Uses a team-based approach.
- Service plans are built on strengths and based on individual needs.
- Ongoing regional support and training available.
- Assessment and outcome instruments used to evaluate success and guide implementation.

Population to be Served

Children who have:

been placed out-of-home or who are at risk of out-of -home placement as evidenced by:

used crisis intervention or intensive wraparound in the past year to maintain community placement

had 3 or more state hospitalizations in the past year or at least one continuous 60-day hospitalization

DSS substantiated abuse, neglect, or dependency in the past year

been expelled from 2 or more daycare or pre-kindergarten classes in the last year

been convicted of a felony or 2 or more misdemeanors in juvenile or adult court, or currently placed in a youth academy program, prison, juvenile detention center, or jail in the past year

other

AND HAVE

DSM-IV diagnosable mental or behavioral disorder

AND HAVE

Severe functional impairment the substantially interferes with or limits roles or functioning in the family, school or community activity (Determined by CAFAS score of 90 or a CAFAS score of 60 with at least one domain having a score of 30.)

AND HAVE

Extreme levels of psychosocial risk (Determined by AOI Part 1 Resiliency assessment.)

AND

Need services from more than one child-serving agency (Mental Health, DJJDP, DSS, Health Care, other providers and organizations). Includes children with chronic health conditions.

Priority Populations

- Former Willie M. class members
- Children who are at imminent risk at being placed in DSS custody, training school, or state hospital due to lack of necessary mental health services*.

**Children who are deaf, hard of hearing, sexually reactive or aggressive are not specified separately because the nature of their treatment needs is expected to fall into the priority populations category.*

IMPLEMENTATION THROUGH A SOC APPROACH

Child & Family Teams

- Direct services are planned and provided through a team approach
- Front-line service providers from all participating agencies work together to develop one integrated plan, coordinated through one primary case manager
- Every child and family's service plan is individualized to meet the unique needs of that child and family
- Every service plan has a crisis component with an emphasis on diverting the child from inappropriate placement into DSS custody, training school or state hospital
- Families are full partners on the teams
- Team members share responsibility and accountability to maximize all local resources in order to achieve measurable outcomes for the child and family

Community Collaboratives (CC)

- Local program directors and decision-makers (Area Program directors, Chief Court Counselors, DSS Directors, etc.) work together as a team
- Oversee and collaboratively support their front-line service provider's work together in Child and Family Teams
- Identify training needs, policy barriers, and resources required to promote comprehensive local service delivery
- Oversee and monitor waiting lists of children if/when there are insufficient funds to provide a particular service
- Share responsibility and accountability to maximize all agency and community resources to fill service gaps in the community's service array

State Collaborative

- State-level representatives from DMH/DD/SAS, DSS, DJJDP, families, advocates, and other stakeholders work together as a team
- Addresses policy issues and promotes changes necessary to help communities develop comprehensive service delivery
- Shares responsibility and accountability to oversee implementation of statewide programming across agencies
- Serves as a resource to Community Collaboratives
- Promotes successful implementation for local Systems of Care

The Role of Area Programs

- Provide the primary coordination functions required for eligibility determination and case management
- Work with local Community Collaboratives to maintain waiting lists, if needed
- Work with local Community Collaboratives to form and serve on teams
- Ensure that Child and Family Teams are available to serve children who are At-Risk, and their families
- Ensure that families receive Family Information Packets (resource information, service plans and other information to support active participation of families in their children's care)
- Assume responsibility for relaying budget issues related to the waiting list the Community Collaborative.

Community Self-Assessment Tool

This self-assessment tool is a modification of a Self Assessment Guideline developed by Sheila Pires, Human Services Collaborative.

VISION AND GOALS

- What are the major goals for our community's System of Care (SOC) initiative?
- In five years, where do we want our community's SOC to be?
- What are our plans to grow our system over the next 5 years to serve more of those estimated to be in need?
- What are our plans to develop a System of Care over the next 5 years to address this need?
- Do consumer families, local partner community-based organizations, and partner public child-serving agencies share a similar vision? How do we know?

STRATEGIC PLANNING & PUBLIC AWARENESS

- What formal and informal planning processes are being applied in our community that are related to System of Care development?
- What other strategic planning efforts are under way around reforming children's services in our community and how are these efforts coordinated and integrated with the SOC development?
- What discussions are underway in our community about integrating policy and programmatic changes related to managed care, the child health insurance program, welfare reform, child welfare reform, etc.?
- Are the public agencies, private community-based organizations, and families involved in these planning processes?
- What population do we want our System of Care to serve? What are the types, amounts, and costs of services needed and how will we fund our reformed

System of Care?

- How will governing boards of other child-serving agencies/organizations in our community be involved in the local SOC development?

- How will other community groups be informed about the local SOC development?

- How will we communicate with key decision-makers in our community to make them aware of the local SOC development?

STATE AND COMMUNITY RELATIONSHIPS

- How do we envision the roles of the state and our local community in the continuation of our existing local SOC?

INTERAGENCY COLLABORATION

- What existing governance structure for interagency collaboration do we have in our local community?

- Are all the key child-serving agencies and other key stakeholders such as providers, consumer families, businesses, churches, press involved in a meaningful way?

- How well is our current interagency structure working? Is there a mechanism for institutionalizing this structure?

- What role does the interagency collaborative play in budget decisions and monitoring of expenditures to support the local System of Care development?

- What are the major interagency issues that we are wrestling with currently?

- What are we now doing that is especially strong that we can build on over the next year?

FAMILY INVOLVEMENT AND FAMILY SUPPORT

- What are the organized groups of consumer-families that provide advocacy, training; support, and information for families with children or adolescents with serious emotional disturbance in our community?

- How are consumer families involved in making decisions at both the policy and practice levels?

- Is consumer family involvement working and is it meaningful?

- Have we been able to involve a broad representation of families of color, varying income groups, families using services from the different child-serving agencies?

- What supports are provided to facilitate family involvement, e.g. transportation costs, reimbursement for time, child care, training?

CULTURAL COMPETENCE

- What are the major cultural/racial groups in our community?

- Do we have a plan/mechanism/activities for addressing cultural competence in our community?

- Does the plan address changing, adopting, or implementing policies and training in order to ensure that our System of Care is culturally competent? How?

- How do we ensure that different cultural/racial groups are involved in the planning?

- Have we surveyed access and service utilization patterns for children of color?

SERVICE ARRAY

- To what extent does our community have a comprehensive array of services and supports for children and adolescents with severe emotional disturbance?

- What is needed to help children remain in their home or return to their home or community?

- What service gaps exist or what are major unmet service needs in our community? What evidence supports this?

- Is our service capacity balanced in terms of services such as inpatient, residential alternatives, intensive nonresidential, respite, home-based, and outpatient as well as informal services and supports?

- How do we create individualized service plans that have the flexibility to develop services and payments that are unique and flexible?

- How are decisions about funding made?

- How does our existing SOC address the needs of older adolescents transitioning into the adult system?

SERVICE INTERVENTIONS/CLINICAL PRACTICE

- How available and accessible are quality services to children and adolescents with severe emotional disturbance and their families?

- How are clinical decisions about kind and length of service made? What is the role of the child's family in making these decisions?

- Are child and family outcomes clearly determined at the beginning of service delivery? How?

- How do we monitor outcomes?

- What types of case management/service coordination are we using?

- Do interagency teams develop individualized service plans in our community and how does a lead agency get designated?

- How do we use both formal and informal supports as part of our individualized planning process? What are the informal supports?

SERVICE PROVIDERS

- Does your community collaborative/interagency council provide direct services? Which services? What are the strengths and barriers?

- Are some services contracted out? Which services? What are the strengths and

- What does the provider pool look like in our locality? Is it adequate in capacity? Training? Where are the gaps? Who is responsible for training?

- How do we, as a community and individual agencies ensure our workforce has the skills, knowledge, and attitudes to implement a System of Care: Is there a mechanism to address workforce issues?

- Do service providers in our local System of Care include nontraditional as well as credentialed professionals?

INTEGRATED FUNDED

- Has our community been able to pool funds? Generate flexible dollars?

- Has our community collaborative been able to redeploy or reinvest funds from restrictive settings (hospitals) to community-based settings?

- Has your community generated new dollars to serve children and adolescents with severe emotional disturbance?

- What are the major funding streams that we are using (Medicaid/EPSDT, Title IV-B, E, Education, Part H, Block grants, State Child Health Insurance Program, foundations, others) and have we been able to maximize the revenue available for service development?

DATA COLLECTION/CLIENT INFORMATION

- Does our community have the capacity for collecting and analyzing data; i.e. fiscal, program and client outcomes, and demographics, in order to inform decision-making about our System of Care?

- Who is responsible for data collection, storage, and analysis?

- Which agencies collect information on children's services and what are the common data sets and needs?

- What are the mechanisms for sharing or cross matching data across child-serving agencies and providers?

MONITORING AND EVALUATION

- How do we evaluate the progress and effectiveness of our system's development and implementation?

- What reports are available from our agencies' data systems that can help us evaluate our SOC? How are these reports used to evaluate the quality of care and to inform the public and other key audiences?

- Do we have a system for quality assurance in our System of Care? How does

this relate to the evaluation of our overall system?

- How are we measuring outcomes for the system as well as for children and families?

Assessing Your Collaboration: A Self-Evaluation Tool

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Many individuals and groups recommend working together to form strong problem-solving collaborative relationships to improve the present status and future well-being of children, families, and the communities in which they live (Carnegie Council on Adolescent Development, 1992, 1995; Dryfoos, 1990, 1994; Lerner & Simon, 1998). Moreover, many local, state, and federal children, youth, and family initiatives now require collaboration among multiple sectors (Borden, 1998).

Presently, Extension professionals and community groups are working collaboratively to develop innovative solutions to promote positive development in children, youth and families. Effective collaborations are able to generate positive outcomes for the audiences they serve. Collaboration is defined as "a process through which parties who see different aspects of a problem [or issue] can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible" (Gray, 1989, p. 5).

Many scholars have suggested that there are key features involved in the collaborative process. For instance, Ash (1989) emphasize the idea of specific factors underlying characteristics of inter-organizational relations; other scholars (Caplan, 1988; DelPizzo, 1990; Kull, 1991) focus on central features or salient themes of partnership arrangements. Still others outline strategies that can assist collaborators when facing challenges and difficulties (Gomez, 1990; Otterbourg & Timpane, 1986).

Recently, other scholars have identified common factors and characteristics influencing the collaborative process. For example in their comprehensive review of collaborative factors, Hogue, Parkins, Clark, Bergstrum, and Slinski (1995) from the National Network for Collaboration identified specific factors, such as leadership, communication, community development, and sustainability. In an empirical study, Keith et al. (1993) identified five major characteristics: leadership, unity, communication, participation by citizens, and informal organizations, and successful accomplishments. Borden (1997) has identified four

factors: internal communication, external communication, membership, and goal setting.

Given the importance of these factors, a self-evaluation tool was developed to assist existing and forming groups. The tool is a self-assessment exercise allowing groups to rate their collaboration on key factors. Key factors examined here include goals, communication, sustainability, evaluation, political climate, resources, catalysts, policies/laws/regulations, history, connectedness, leadership, community development, and understanding community.

With this tool, collaborative groups identified strong factors and challenging factors, that is, factors that need to be worked on. The identification of the challenge factors facing the group can assist in the development of strategies to address these issues, thus allowing the group to move forward and accomplish their goals. In all cases, the self-evaluation tool can be used to strengthen the collaborative group. The following is a description of the Collaboration Check-list.

Collaboration Tips

The underpinning of successful community mobilization is building a foundation of community-appropriate and community-determined objectives, incorporating strategies based upon local opportunities and the community's strengths
(Annie E. Casey Foundation, Rebuilding Communities Initiative, 2000)[1]:

Helpful tips about how to collaborate effectively:

- Promote local ownership by engaging local community members through participation in the planning processes - from the beginning. Local citizens can help a collaborative determine how to best to reach out into its local community and engage residents and other prospective collaborators;
- Include decision-makers from local and state government and business in the local effort in order to effect lasting systems change and capture additional resources;
- Engage - don't compete with- other capable collaboratives;
- Actively solicit the involvement of relevant agencies in planning how public resources and systems should be part of the community reform process;
- Help citizens and community representatives build the skills necessary to assume leadership, identifying partners and collaborators to work closely with the lead organizations in planning and eventually taking on leadership of the collaborative;
- Continue to engage participants through involvement in local governance structures that monitor and guide plan implementation. This level of participation - over time - creates the new leadership and local power necessary to continue promoting community interests, thereby sustaining the collaborative structure.

Tips on how to maintain active participation:

One of the common difficulties experienced by collaboratives is in maintaining the active participation of collaborative representatives. It is important to set priorities that focus the initial vision into a practical work plan. As noted previously, the benefits of participation must outweigh the time and work burdens of one more meeting for busy people. Experienced community mobilization leaders understand the importance of scheduling and running meetings (Dombro, et al. 1996):

- Begin by coordinating the schedules of the most essential representatives for each meeting - the partners that must be present to provide critical information, help make decisions or lead discussions;
- Set regular meeting dates so that participants can reserve the time beforehand. Schedule several meetings in advance;
- Keep mailing lists up to date. Use 'fax-back' RSVP forms;
- Use phone meetings and conference calls with in-person attendance is impossible

- Require that only participants who attend meetings have voting privileges to avoid substitutions of key decision makers;
- Run efficient meetings and create incentives for attending - start and end on time, stick to the agenda. Include great snacks!

A Collaboration Checklist

Each of the following factors influences the collaborative process. After reading a brief description for each, place an X in the box (see Figure 1) that best reflects your opinion of how your collaboration is functioning in each of the areas using the following scale: 1 = Strongly Disagree, 2 Disagree,
3 = Neither Agree or Disagree, 4 = Agree, and 5 = Strongly Agree.

1. Communication - the collaboration has open and clear communication. There is an established process for communication between meetings;
2. Sustainability - the collaboration has a plan for sustaining membership and resources. This involves membership guidelines relating to terms of office and replacement of members;
3. Research and Evaluation - the collaboration has conducted a needs assessment or has obtained information to establish its goals and the collaboration continues to collect data to measure goal achievement;
4. Political Climate - the history and environment surrounding power and decision making is positive. Political climate may be within the community as a whole, systems within the community or networks of people;
5. Resources - the collaboration has access to needed resources. Resources refer to four types of capital: environmental, in-kind, financial, and human;
6. Catalysts - the collaboration was started because of existing problem(s) or the reason(s) for collaboration to exist required a comprehensive approach;
7. Policies/Laws/Regulations - the collaboration has changed policies, laws, and/or regulations that allow the collaboration to function effectively;
8. History - the community has a history of working cooperatively and solving problems;
9. Connectedness - members of this collaboration are connected and have established informal and formal communication networks at all levels;
10. Leadership - the leadership facilitates and supports team building, and capitalizes upon diversity and individual, group and organizational strengths;
11. Community Development - this community was mobilized to address important issues. There is a communication system and formal information channels that permit the exploration of issues, goals and objectives; and,
12. Understanding Community - the collaboration understands the community, including its people, cultures, values and habits.

Figure 1 : The Collaboration Checklist

	Strongly Agree 1	Somewhat Disagree 2	Neither Agree nor Disagree 3	Somewhat Disagree 4	Strongly Disagree 5
Goals	____	____	____	____	____
Communication	____	____	____	____	____
Sustainability	____	____	____	____	____
Research and Eval.	____	____	____	____	____
Political Climate	____	____	____	____	____
Resources	____	____	____	____	____
Catalysts	____	____	____	____	____
Policies/Laws/ Regulations	____	____	____	____	____
History	____	____	____	____	____
Connectedness	____	____	____	____	____
Leadership	____	____	____	____	____
Community Development	____	____	____	____	____
Understanding Community	____	____	____	____	____
Totals	____	____	____	____	____
Grand Totals	____	____	____	____	____

Identifying the collaboration's strengths and challenges assists the collaboration in determining the best course of action to achieve its identified goals. For example, if the group scores from 0-30 the collaborations has many components that comprise a successful collaboration. There are goals, working members, and strong leadership. If the collaborative group scores between 31-48 the group has some of the factors; however, there is some need to develop the inter-workings of the group. The group may need to determine new ways of working together. However, if the group scores between 49-65 the group may wish to refocus their goals and leadership. Establishing a group's strengths and challenges can serve as a springboard to building a more effective collaborative group.

Inventory to Identify Community Strengths

Please rate your county's System of Care regarding the following characteristics, and explain why in the space provided.

	never				always
1. Put the needs of the child and family first.	1	2	3	4	5
2. Keep services based in the community.	1	2	3	4	5
3. Offer services that are culturally competent.	1	2	3	4	5
4. Offer a range of services that meet the needs of children and families with special needs.	1	2	3	4	5
5. Offer services based on the strengths and needs of each child and family.	1	2	3	4	5
6. Offer services that keep the children in their homes if possible.	1	2	3	4	5
7. Involve families as partners in the planning	1	2	3	4	5

process.

8. Offer coordinated services across agencies. 1 2 3 4 5

		never				always
9.	Offer case management services.	1	2	3	4	5
10.	Offer services that are responsive to cultural differences and special needs of children and their families.	1	2	3	4	5
11.	Promote early identification of and intervention for children with special needs.	1	2	3	4	5
12.	Offer smooth transition to adult services	1	2	3	4	5
13.	Protect the rights of children and promote advocacy for children and their families.	1	2	3	4	5

Excerpted from:

The Politics of Help
Building Collaborative Infrastructures in the Human Services

By John Franz

Glisson, Charles, and Anthony Hemmelgarn. 1998. "The Effects of Organizational Climate and Interorganizational Coordination on the Quality and Outcomes of Children's Service Systems." Child Abuse and Neglect 22 (5): 401-21.

Martin, Lisa M., Carey L. Peters, and Charles Glisson. 1998 "Factors Affecting Case Management Recommendations for Children Entering State Custody." Social Service Review 72 (4): 521-44.

Building the between

Frequently when communities begin to implement the wraparound approach, they emphasize changing the way line staff do their work. Social workers, probation officers, special education teachers and mental health providers are taught the steps of strength-based action planning and how to facilitate or participate on child and family teams. Some alterations may also be made in assignments – for example, people who facilitate teams may be given lower caseloads, or staff may be hired who provide only care coordination. The folks with new assignments usually work within a pilot project, while everyone else continues in their pre-existing roles. The plan is to gradually expand the new practice methods to include other units and agencies.

Unfortunately, many communities have found it difficult to move from the pilot stage to broader implementation using this strategy. Charles Glisson and his colleagues at the University of Tennessee have documented the barriers to achieving and sustaining large-scale changes in practice, even when extensive training, support and guidance are provided to line staff. Glisson's conclusion is that effective change must address the culture and climate of the work environment in addition to helping staff learn and use new skills. This observation has been supported by an extensive amount of research on organizational change in the private sector. For line staff to adopt a new method of practice, the context in which they work must be aligned with, teach and reinforce the desired approach.

Although changing the organizational culture in a private corporation is difficult, modifying the operating context in human services is even more of a challenge. This is because most of the work is by its nature a multi-agency effort. To produce sustained change, not only must the environment and protocols within each participating public and private agency be addressed, but equally importantly, the relationships between and among these entities must also be improved, as must the interactions between them and the larger community

To move from traditional categorical operations, which divide not only service disciplines but also service organizations, to the integrated model of the wraparound approach requires that we pay as much attention to building a strength-based, inter-agency infrastructure as we do to teaching people how to do strength-based planning with families.

This infrastructure has four tiers or components: practice, program, system and community. The practice level captures the changes in methodology that we are hoping to accomplish. The program level addresses the changes in operations that must take place in each agency that houses staff who are expected to do their

work in a new way. The system level incorporates the interagency protocols and agreements that provide a template for collaborative support for families. At the community level, the emphasis is on improving the functional connection between the emerging System of Care and the community's key stakeholders as represented by business organizations, consumer and advocacy groups, government agencies, faith-based groups, service clubs, etc.

For a large-scale transformation to be successful, a common vision must emerge that both unites and animates all of these elements. We must rally the sustained passion needed to build and sustain the "between" of our human service enterprises.

Why explore the between?

Anyone who has been a part of an organizational change effort of any size knows how challenging these projects can be. Often, attempts at significant transformation even within a single agency run into endless roadblocks – and that's when everyone agrees that a better way of operating is needed. The resiliency of the organizational status quo has repeatedly amazed those who study the change process.

As hard as it is to get one organization to change, it's a cakewalk compared to the challenge of redefining relationships and protocols in a multi-agency System of Care. Some sort of geometric multiplication of stuckness seems to emerge. Communities often find their intersystem structures operating at the lowest common denominator of their most inflexible component.

So why bother with the between? Because in the case of human service systems, it may be that the invisible network among these institutions – the community's culture of care ñ is the greatest contributor to the inertia experienced within any single agency or department. Unless we can overcome its impact, it is unlikely that line staff will be able to make and sustain significant changes in practice.

This is not to suggest that there is a simple linear relationship among changes in the four levels of a community's System of Care. Instead they are constantly interacting with one another and in turn all are being influenced by external factors in the state and the nation.

At any point in time communities attempting to implement wraparound will find themselves at different stages of integration on each of the four levels. Table One illustrates examples of four degrees of growth for each level. The first stage takes place when people, programs, systems or communities work together on an ad hoc basis. At the second stage, a limited amount of structured cooperation occurs. In stage three, a formal system of collaboration is established. The final stage, integration, only emerges when help squads can form as effortlessly for families with complex needs .

Around the country, communities that are in the process of establishing integrated systems of care will demonstrate different patterns of implementation. One might be at the collaborative stage in the practice and system levels, while still at the ad hoc or cooperative stage in the program and community levels. Another will have a well-developed community component, but still be at an early developmental stage in other areas. If there is a proper sequence for working through the levels, no one has found it yet.

To become more effective at building the between we must improve our ability to recognize the complex nature of this pattern, gain a better sense of where things stand at each point of time within the ongoing turmoil, and learn to take advantage of opportunities for improvement in any of these elements as they occur.

Table
Degrees of Integration across the Levels of Human Service Operations

	Ad Hoc	Cooperative	Collaborative	Integrative Practice
	Staff from two or three agencies may decide on their own to work together to help a family.	Certain staff in a pilot project are trained to convene and facilitate child and family teams, but must recruit other participants.	A model is developed that allows staff from multiple agencies as well as other informal community partners to work together in certain circumstances.	From the perspective of children and families all needed assistance is available through one contact, regardless of the point of system entry.
Program Level	Staff in an agency are encouraged to cooperate with colleagues when ever possible.	Two or more agencies include cross-training and shadowing components in their respective in-service programs to improve collaborative work.	Agencies recruit, train and reward staff for their capacity to engage in creative, reciprocal helping efforts with families, other agencies and community stakeholders.	Agencies reshape their internal structure and operations to improve their ability to work in close partnership with one another.
System Level	The administrators or managers of some agencies and departments begin meeting to improve inter-agency communication.	An interagency agreement is signed, perhaps as part of a grant application, and formal interagency meetings occur.	Formal operational linkages among agencies are established and regularly used to serve children and families.	A unified system for assessment, planning, information management and service delivery is adopted and used.
Community Level	Stakeholders meet from time to time around specific issues.	Some structured, ongoing community groups are formed.	A formal organization has been created to support collaborative policy development among all human service agencies.	A cohesive, empowered, community-wide decision making entity has been established to guide cross-system operations and resource access.

Understanding “Collaboration”

Adapted from:

“Collaboration for a Change: Definitions, Decision-making models, Roles and a Collaboration Process Guide” by Arthur T. Himmelman. Permission to photocopy and distribute is granted by the author.

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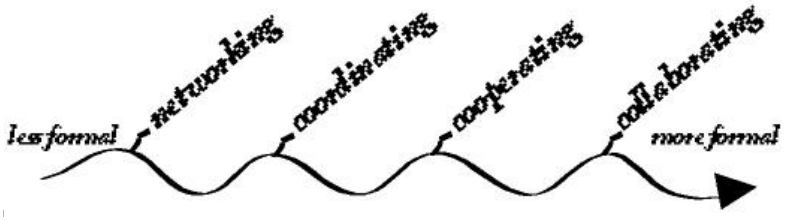

Along a continuum of strategies for WORKING TOGETHER, collaboration is more formal and complex, requiring more commitment than other popular strategies for sharing responsibilities and resources.

1. Networking

Networking is defined as exchanging information for mutual benefit. It is the most informal of the interorganizational linkages along the continuum. Networking reflects an initial level of trust, limited availability of time, and a reluctance to share turf.

example: A hospital and a community clinic exchange information about subst**ance abuse treatment services.**

2. Coordinating

Coordinating is defined as exchanging information and altering activities for mutual benefit and to achieve a common purpose. Coordination eliminates or reduces barriers, thereby making services more “user friendly.” Compared to networking, coordinating takes more time, requires higher levels of trust, yet little or no access to each other’s turf.

example: A hospital and a community clinic exchange information about substance abuse treatment services and decide to alter service and clinic schedules to meet the needs of common clients.

3. Cooperating

Cooperating involves exchanging information, altering activities, and sharing resources for mutual benefit and to achieve a common purpose.

Cooperating requires more organizational commitment then networking or coordinating and in some cases may involve written or legal agreements. Cooperating organizations share resources – human, financial and technical– which can include shared knowledge, staff, property, and dollars. Cooperating can require a substantial amount of time, high levels of trust, and significant access to each other's turf.

example: A hospital and a community clinic exchange information about substance abuse treatment services. They decide to alter clinic schedules and agree to share clinic space and funding to meet the needs of common clients.

4. Collaborating

Collaborating is defined as exchanging information, altering activities, and sharing resources and enhancing the capacity of another for mutual benefit and to achieve a common purpose.

The qualitative difference between collaborating and cooperating in this definition is the willingness of organizations (or individuals) to enhance each other's capacity for mutual benefit and common purpose. This definition also assumes that with collaboration comes shared risks, responsibilities and rewards. Collaborating is usually characterized by substantial time commitment, very high levels of trust, and extensive areas of common turf.

example: A hospital and a community clinic exchange information about substance abuse treatment services. They decide to alter clinic schedules and agree to share clinic space and funding to meet the needs of common clients.